Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SHAHID SYED, MD
PO BOX 121589
ARLINGTON TX 76012

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-10-4586-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid per the DWC Fee Guidelines"

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's report does not reflect any determination the claimant's disability resulted from the compensable injury. Instead, the report documents extent of injury."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 19, 2010	CPT Code 99456-W7-RE	$250.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 24, 2010

   - CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED, WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.

   Explanation of benefits dated April 22, 2010 with above codes as well as the additional reason codes:

   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
   - CAC-W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Issues

1. Did the requestor perform the services as requested on the DWC EES-14 DDE Notification?
2. Is the requestor entitled to reimbursement?

Findings

1. The services requested per the DWC EES-14 notification were that Maximum Medical Improvement, Impairment Rating, Return to Work and Direct Result determinations were to be accomplished. The denials based on documentation 16 and 225 reflect a discrepancy between what was billed and what was performed. The carrier denies the 99456-W7-RE as while ordered and billed, the narrative and reports attached show that an extent of injury determination was rendered instead, which was not requested. The Division finds that there was no order to perform a "extent of injury" evaluation as documented but rather a "direct result" determination and therefore it is not payable.

2. In accordance with 28 Texas Administrative Code §134.204, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 20, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.